PARTNERSHIP PROGRAM SERVICE DELIVERY MODELS: CONSIDERATIONS AND SELECTION

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CONSIDERATIONS FOR PARTNERSHIP MODEL SELECTION

At the heart of the Wisconsin Partnership Program is an interdisciplinary care management team. While an interdisciplinary team may not be novel, the Partnership team is unique in several ways that will be described below. This uniqueness comes, in part, from a commitment to highly integrated, consumer centered care that is different in both philosophy and practice from other interdisciplinary teams.

History and Development of the Interdisciplinary Partnership Team

The idea for the Partnership team model grew out of concern over the highly fragmented nature of long-term care and the negative impact that fragmented care delivery systems have on consumers. The Wisconsin Partnership Program developed out of a collaboration among diverse stakeholders who were all committed to designing a model of long-term care that was high quality and highly responsive to consumers. Bringing together providers who represented many of the systems and services used by long-term care consumers, in particular long-term support services, the goal was to design a single system. Long-term care in Wisconsin is similar to long-term care across the U.S. and around the world. Social services and long-term support are provided by a network of providers in one (more or less cohesive) system. These long-term support systems are operated by community-based organizations that are quite separate from the multitude of organizations that provide health care to the same populations. Health services are governed and regulated by different state agencies than those that govern long-term support systems and services. These two systems remain largely separate. They relate to each other primarily through referral and maintain, in many instances, an uncomfortable and largely ineffective partnership. Evidence of this ineffectiveness comes in many forms. Social workers from community-based support programs frequently express frustration over the difficulty they

experience trying to work with physicians who provide care to their clients. Efforts to contact physicians and learn about the health issues their clients are struggling with are sometimes not responded to at all and other times are met with statements about patient confidentiality. This leaves social workers and other long-term support workers with inadequate information about the needs of their clients and undermines their effectiveness as care managers. Other evidence is provided by the all-too-frequent hospital discharge planning that is done without the awareness (and consequently inclusion) of a consumer's well-established community support system, creating a new, redundant and less effective support network. An area of ongoing tension, and source of increased cost to the state, is the rate at which consumers discharged from hospitals are sent to local nursing homes rather than being sent home. In at least some instances, consumers could return home with adequate community support if discharge planners were aware of and able to work with community support systems. Consumers also experienced difficulty on a regular basis following the instructions of their health care providers. Sometimes this is related to different circumstances at homes, sometimes to lack of financial resources, sometimes to incompatibilities between these instructions and the organization of their work or personal lives and sometimes to confusion related to multiple providers.

These are the types of problems that the Wisconsin Partnership Program was designed to address. Doing so successfully obviously requires input and cooperation from both the health care and the social support systems. (This is sometimes referred to as acute and long-term care. This distinction is misleading, however, since it implies that health care services are only acute and episodic rather than ongoing and that social support is not relevant to acute illness episodes. This population is distinct in its ongoing need for both.) Designing a long-term care/support plan for a consumer requires understanding and inclusion of health issues. Planning health care services for

this population requires the understanding and inclusion of community, family, and social services. Lack of integration, in the form of two well designed but separate plans, leaves the consumer with the challenge of putting them together.

With these issues and challenges in mind, the Wisconsin Partnership Program was designed to bring these systems together within a single organization, operating through a single team.

Designing responsive, high quality systems to manage health and social services for frail, chronically ill populations continues to be undermined by a variety of factors. These include fragmentation and discontinuity of services, cost shifting, territorial conflicts among providers, exclusion of consumers from meaningful participation in planning and evaluation, confusion over access to appropriate and available services, and significant mismatches between services available and services needed. The resulting development of multiple parallel service delivery systems, each specializing in and advocating for a particular service or population has created a confusing and relatively unresponsive maze. Consequently, successful accessing, developing, and/or maintaining the services needed by vulnerable populations has only been possible where strong advocates and case managers intervene continuously.

These problems can be effectively addressed only if the larger systems within which services are developed and delivered are substantially changed. For that reason, systems change is an important aspect of the proposed model. It is not sufficient, however, to eliminate the system sources of ineffective care delivery. Consumers and providers alike have become accustomed to the fragmentation, discontinuity and lack of either accountability or participation in service development and evaluation. The continuation of usual practice patterns is likely to perpetuate

the problems described above, despite system changes eliminating the necessity for doing so. Current service delivery practices are unlikely to change significantly unless addressed directly.

Therefore, in addition to structuring a system that creates the possibility for collaboration, continuity, and active participation of consumers, we have carefully examined several clinical models in order to select one that is likely to facilitate the above goals.

In particular, the structure of the core clinical team will determine, to a great degree, the likelihood of achieving these goals. Creating a structure that actually precludes the usual patterns of fragmentation and discontinuity was the goal.

The process used to develop the new, integrated model was to create a task force of practitioners, supervisors, and administrators representing the core team disciplines (nurse practitioners, social workers (SW), physician, case managers) who were working with the target population. Task force members worked together over a period of four months to examine the structure and implications of several clinical models developed by the group to identity the most predictable sources of fragmentation, conflict and breakdown in the current system, and to design a clinical model that would enhance the delivery of clinical services.

The following considerations were identified by the task force as central to the development of such a model:

1. What are the team building/collaboration implications of each model?

2. What are cross-site continuity implications of each model (including nursing home, hospital, home)?
3. What are the implications of each model for replicability in rural/urban settings?
4. What are the consumer participation implications of each model for?
5. How will utilization review, quality improvement, continuing education be influenced by model types?
6. What are the options for structuring a close hospital link within each model?
7. What are the implications of each model for recruiting, supervising, and maintaining a pool of home care and other ancillary workers?
8. What are access/entry point implications of each model?
9. What are systems and individual accountability implications of each model?
10. What is the relationship between financial risk and decision making/resource utilization authority in each model?

Models Considered

These questions were discussed at length. The following recommendations were agreed on, and used to determine the final Partnership team model.

1. The organization assuming the risk must have primary authority over the development, implementation and evaluation of a service plan. The task force considered and rejected those clinical models that separated decision making authority from financial liability or that split financial accountability between organizations. Both of these options maintain incentives for cost shifting and limit team members' access to information relevant to clinical decision making.

2. The geriatric nurse practitioner (GNP) and the social worker must operate as a collaborative team (core team) rather than through referrals based on clear divisions of authority and expertise. The models that divide decision making authority either between organizations, providers, or service type were rejected since such divisions are known to undermine collaboration and the effectiveness of team operation. True collaboration requires that the core team members share both physical location and decision making responsibilities.

The primary link to the private physician, and the coordination of health related services across settings, would be the responsibility of the geriatric nurse practitioner. The GNP would be the primary assessor and decision maker for nursing and chronic health/medical problems. In collaboration with the Partnership physician, the Partnership team would assume primary responsibility for home assessments, the development of a long range plan, the coordination of social support and medical services in the home, and the facilitation of transitions across health care settings.

The selection of the GNP as the primary link to the private physicians in the Partnership Program, and as the final clinical decision maker, is based on research data demonstrating the effectiveness of GNPs in preventing and limiting the use of acute and institutional long-term care services in frail elderly populations, increasing patient satisfaction, preventing medical complications, resulting in shorter hospital stays and a reduction in hospital readmissions (Ethridge & Lamb, 1990; Marschke & Nolan, 1993; Mundinger, 1994; Sox, 1979).

The concern on the part of some social service providers that combining health and social services leads inevitably to a medicalization of all aspects of the consumers' lives, was discussed at length. It was addressed by establishing the core team as the primary decision-maker for all discussions, rather than dividing the labor or the responsibility between the health and social service providers. This is a unique arrangement in which each care issue is addressed by the entire team. This contrasts sharply with the strategy generally used by interdisciplinary teams in which each discipline is primarily responsible for a circumscribed area and reports to the team on progress and problems in their specified areas. It also contrasts sharply with physician dominated teams in which other members try to influence the physician but are not responsible for the final decision. (Team decision making and how it operates is discussed in more detail later.)

3. As a reflection of team collaboration, a single plan of care is developed collaboratively by the team. It is not unusual for individual team members to struggle with this in the beginning. They are used to single discipline plans. This plan will be used to guide the management of each consumer and is used across sites. This is a second unique feature of the Partnership Program. One of the more difficult and most important aspects of a single multisite plan of care is the effective integration of those plans into the delivery of care in hospitals and nursing homes. The Partnership Programs have each developed strategies to establish formal relationships with the inpatient staff of acute care settings, and the staff of nurses here, that allow the GNP and SW to participate actively in planning and decision making in these settings as well as having an ongoing involvement in evaluation of the care.

4. The focus of case management is primarily at the level of clinical decision making and service delivery, not through administrative oversight or system level utilization review (in contrast to usual HMO utilization management practices). This means that providers have access to financial information about individual recipients as well as overall program costs. Cost, quality and clinical outcomes data can also be continually fed back to the clinical team members and the clinical services manager. Each site has established a different mechanism for doing this.

5. The consumer is a central participant in decision making. In this model, the client is placed within the decision making circle along with the SW and the GNP. This represents a very active role for the client in decision making about service utilization and evaluation of both quality and effectiveness.

The models of consumer participation or feedback used in other health care settings do not actively integrate consumers into the development and evaluation of care. In most instances, consumer participation is restricted to post hoc evaluations of general levels of satisfaction and/or satisfaction with a priori provider determined categories of care.

It is a central goal of this project to enhance the participation of the consumers in a way that facilitates effective working of the team, and maintains both a consumer focus while facilitating clinical excellence. In addition to the development of an active consumer advisory board, specific strategies to facilitate consumer participation were developed as the projects proceeded. This was accomplished primarily through an ongoing formative

research project, using intensive interviewing of all consumers and providers during the first year of the program.

6. The exact configuration and involvement of these groups is a question that needs to be examined. Ancillary workers must be included in the design, development, and evaluation of services, service delivery systems, supervisory practices, and continuing education/staff development. In particular, the PCWs are actively included in planning and evaluation of their job design and care standards. It would not be accurate to leave the impression that this was easy. Partnership staff worked hard to achieve these ends. Much of the following discussion addresses how this was accomplished and the obstacles encountered along the way.

II
THE PHYSICIAN PARTNERSHIP PROGRAM

Selected Model Description and Discussion

MODEL KEY

SW - Social Worker

MD - Medical Doctor

GNP - Geriatric Nurse Practitioner

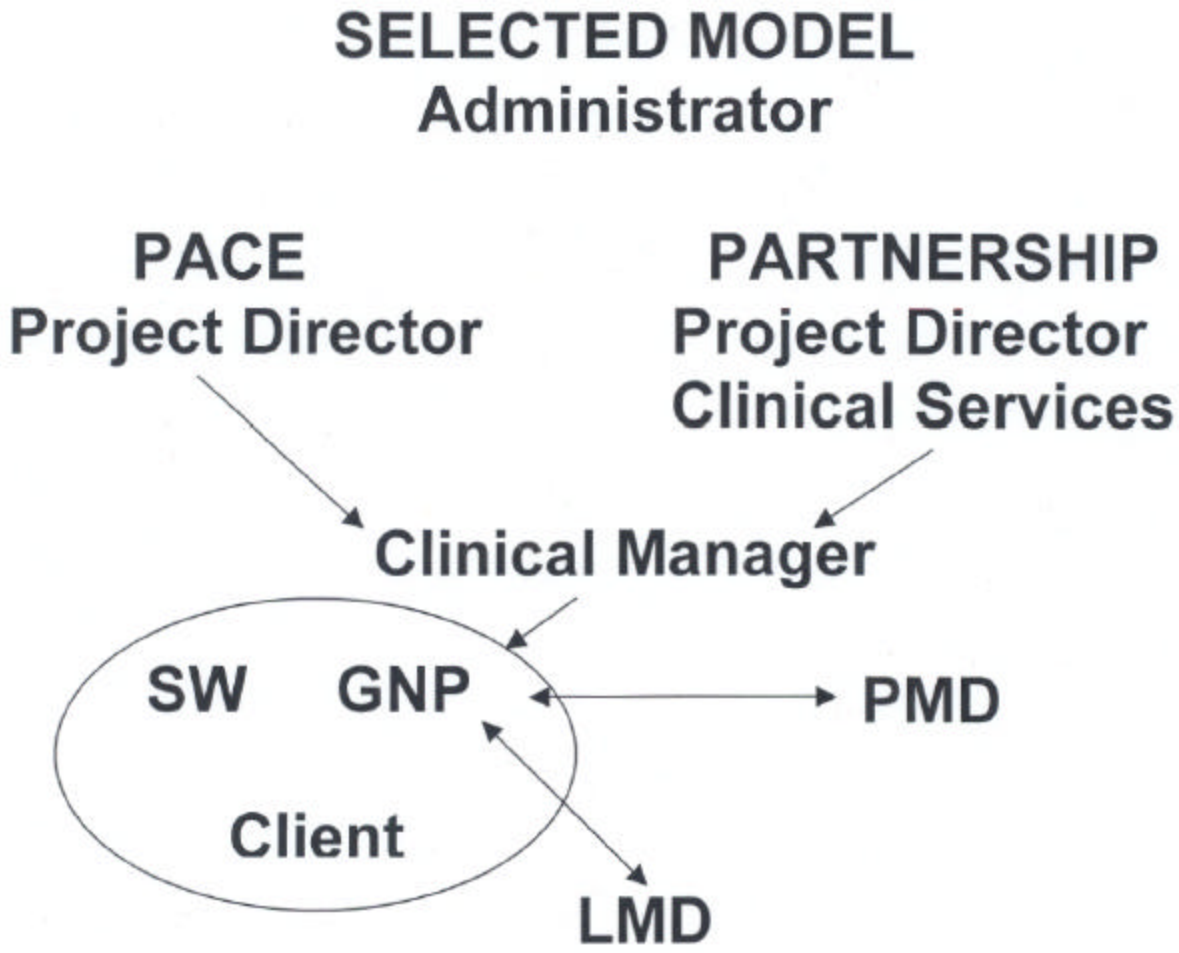
LMD - Local Medical Doctor (Partner Physician)

PCW - Personal Care Worker

PMD - Partnership Medical Director

OT - Occupational Therapy

PT - Physical Therapy



This Partnership Model was designed to facilitate the implementation and evaluation of several innovative strategies for delivering comprehensive care to vulnerable, hard to serve, high cost populations. The Partnership Clinical Model is designed to:

1. **Integrate health and social services.**

   Integration of Health and Social Services will be accomplished by employing and locating both Nurse Practitioner and Social Worker in the same agency. Physical proximity will

enhance the potential for collaboration. Financial accountability and clinical quality will be enhanced by shared financial authority, while also preventing cost shifting.

2. **Integrate services across settings.**

The GNP has a formal relationship with the in-patient setting and in particular, discharge planners. This facilitates a safe, early discharge by providing continuity of the care plan and primary provider across settings. Informal but close working relationships will also be established with nursing homes used by the Partnership Program.

3. **Shift the site of care, to the extent possible, from institutional to community sites.**

The development and supervision of a pool of personal care workers/home health aides within or closely associated with the Partnership Program will facilitate a close working relationship between the core clinical team and the personal care workers. One possibility that will be explored is to include personal care workers, or a representative PCW on the core clinical team. How this will be done is yet to be determined.

The availability of a high quality, reliable, and consistent pool of PCWs, along with the close monitoring of consumers by the GNP will increase the possibility that seriously ill consumers can remain in their homes.

4. **Increase the participation of consumers in decision making about care/service options.**

Including the consumers in the core clinical team's decision making about plans of care is a central goal. This is not an easy goal to achieve, however. A long history of not being

involved in such decision making, serious illness and disability, lack of knowledge, a desire to delegate decisions to a trusted provider and reluctance to voice an opinion have all been cited as reasons that frail elderly are not often directly involved in clinical decisions. Finding ways to include the elderly clients in ways that are comfortable for them is an important goal. Differences between the elderly and the physically disabled on this topic are anticipated.

5. **Increase the involvement of primary care providers as both entry points to care and long-term care managers.**

The relationship between the Partnership Physician and the GNP is designed to assist the physician to keep patients within their practices who they would otherwise institutionalize or refer. It is also hoped that the GNP/Partnership physician relationship will decrease the use of emergency rooms by providing an alternative resource for patients to call upon after hours.

6. **Shift the focus of health care from episodic, acute and reactive management to a preventive, supportive and coordinated approach.**

Providing a GNP and a rich community network with multiple providers and staff trained to assess and monitor patient conditions, it is hoped, will increase the prevention and early intervention that has been shown to decrease hospitalizations. This means that ancillary staff not usually included in clinical care plans will be trained to assist in this prevention effort.

7. **Create and maintain partnerships with multiple provider types in a way that perpetuates the values of Partnership while increasing collaboration and accountability of all providers.**

   Community services that are not developed and managed directly by the Partnership Program will be carefully selected for responsiveness, skill, and shared values. The number of providers and agencies who will work with Partnership Patients will be kept as low as possible to increase the likelihood of workers taking on the values of the program, and decrease fragmentation.

8. **Demonstrate the effectiveness of the geriatric nurse practitioner as case manager for vulnerable, hard to serve, and medically unstable populations.**

   Special attention will be given to the role of the GNP, especially in the role of liaison to other providers and the ability to manage collaboratively with other team members.

Rationale for Selected Model

This model was selected because it met all the criteria recommended by the clinical models work group:

1. The Geriatric Nurse Practitioner, social worker, home care nurses, PCW and consumer are in a collaborative relationship rather than a relationship based on referral.
2. The GNP is the primary link to the Partnership physician.
3. Staff development, supervision, quality review is enhanced through close working relationships rather than referral.
4. Accountability for financial and clinical decisions is shared among team members.

5. The single funding source and shared decision making prevents cost shifting (and the resulting responsibility shifting).
6. A single, collaborative plan of care is facilitated by the shared decision making responsibilities within the clinical team and across settings.
7. Clinical team members are employed and supervised by a single agency to minimize conflicts in philosophy, enhance communication, and maximize personal contact among team members.
8. The GNP and social worker will have formal, direct relationships with hospital floor staff, discharge planners, and nursing home staff. This will be facilitated through an HMO contract that includes an array of services within a single organization.
9. Personal Care Workers will be supervised by Partnership Staff and will be included in team decision making.

Description of the Selected Model

The core team members in the selected model include the geriatric nurse practitioner, the social worker, the home care nurse, and the consumer. The Medical Director to the team will be available to discuss clinical questions, but will not have a direct or formal relationship to either the consumer or the panel of Partnership physicians. The Medical Director (geriatrician) has no authority over the decisions made by the consumers' private physicians, but will be available on a limited basis to consult with the panel physicians in the Partnership Program if they desire.

The role of the GNP in a Partnership Program is quite independent. As the program evolves, new groups with less experience can be hired since they will have adequate internal support and supervision. The first GNP must be very experienced with both medical management of a similar

population and collaboration with physicians. Preventing hospital admissions and readmissions is a major goal of the project primarily because hospitalizations are so dangerous for this population. The incidence of iatrogenic illness, with the consequent costs in quality of life and actual dollars, makes high quality medical management important. The effectiveness of GNPs in managing complicated medical problems in a high quality, cost effective way has been well documented (Mundinger, 1994; Sox, 1979).

A close working relationship between the GNP and the private physicians is a key aspect of the Partnership Program. GNPs will collaborate in a direct, ongoing relationship with private physicians to shift the management of medical problems from institutional/acute care settings to the in home instances where this can be done safely and effectively. In order to support this provision of services in the home, and to convince the private physicians that home management can be done effectively, a clinical services manager hired by the Partnership Program will be responsible for developing the organizational capacity of the Partnership to locate or provide the necessary staff, consultants, and equipment in a timely manner. This function has been achieved in different ways by the partnership sites.

Because of the central importance of transitions from acute care settings back into the community, the Partnership social worker and GNP will maintain formal relationships with the discharge planning staff in the affiliated acute care settings.

Each Partnership team is responsible for a caseload of consumers, following them across settings. This structure is designed to enhance the continuity of care and maximize the possibility that the plan of care developed for each consumer will be used to inform decisions in other settings. This will

increase efficiency, allow home care arrangements to begin early in a hospitalization, and increase the chances that a consumer's wishes (reflected in the plan of care) will be followed.

Team SWs will be responsible for assessing social service needs, arranging for supportive services in the home, and for consumer integration into the community by identifying, creating and/or maintaining informal support networks. Social workers, with years of experience in consumer advocacy, will also play an important role in maintaining the centrality of consumer choice and participation in decision making. Social worker/case managers from the Wisconsin Community Options Program, with experience in consumer advocacy and community development, will continue to serve in an advisory capacity during all phases of the demonstration.

Research Component

The Partnership Program will provide an opportunity for intensive data collection on efforts to maximize consumer participation, examining what enhances and/or impedes effective participation of consumers under a variety of circumstances. The relationship between the nature, timing, and outcomes of consumer participation and consumer willingness to increase the level and nature of their involvement in future decisions, will also be explored using a formative evaluation field research design. Analysis of field work data related to increasing competence and/or willingness of consumers to participate in the management of their own care will be continually fed back to the Partnership team. This data will be used to create a model for developing and maintaining consumer participation.

The field research effort will also provide ongoing evaluation of decision making processes and practice patterns engaged in by private physicians in the Partnership Program. This will include an

analysis of whether, in what way, and with what changes in decision criteria, the Partnership Program is able to influence practice patterns, to shift the location of service delivery, to prevent serious medical complications, and to give consumers a greater voice in a wide range of choices.

Finally, the field research will examine closely the perceptions of quality held by both consumers and providers participating in the program. Special attention will be given to the criteria used to determine quality, the influence of other team members and consumers in provider perceptions of quality, and whether, and in what way, changes occur over time in the criteria used to assess quality of care and quality of life.

KEY FEATURES OF PARTNERSHIP

PROGRAM CLINICAL MODEL

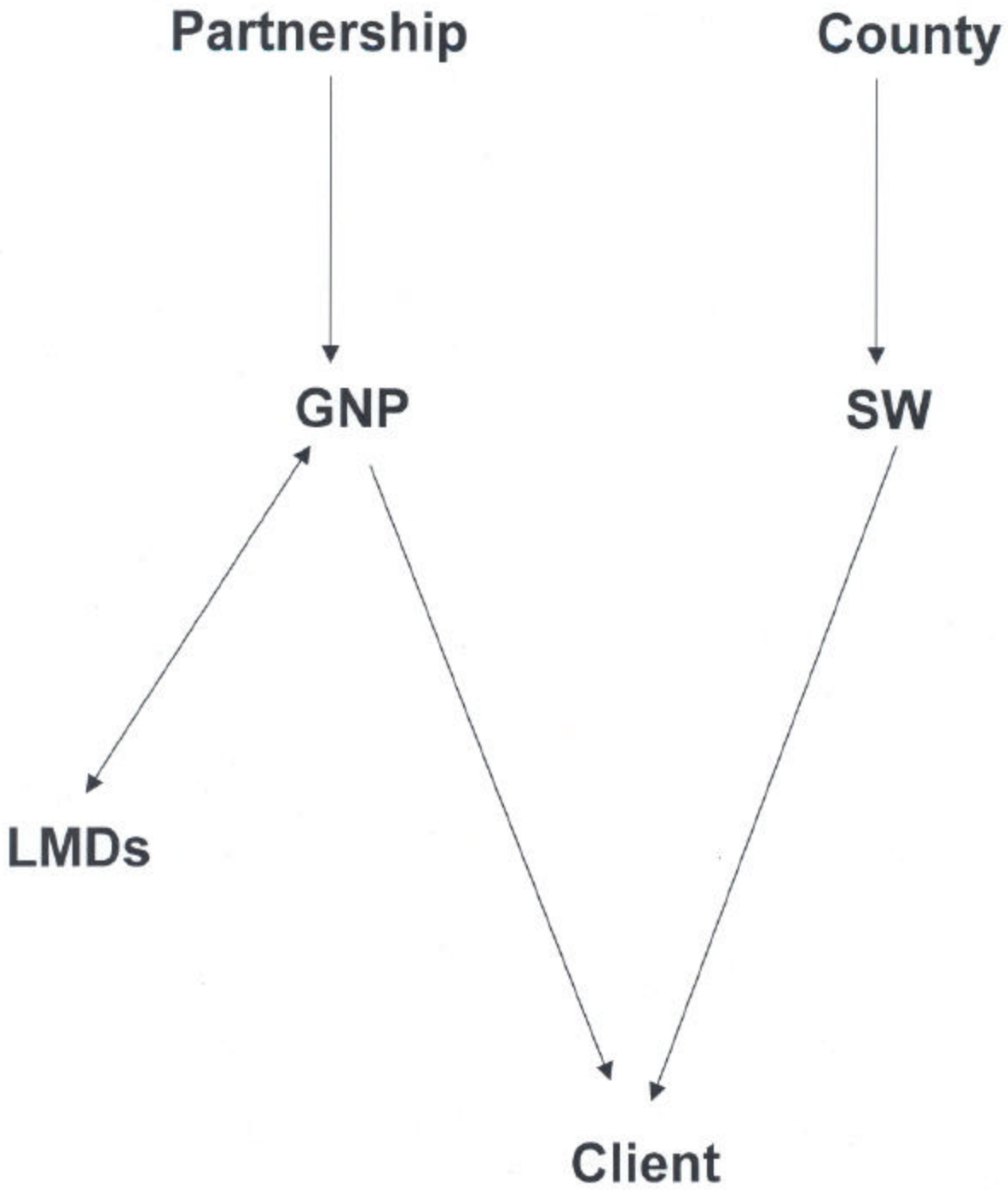
- **CENTRAL ROLE OF GNP**
- **INTEGRATION OF HEALTH AND SOCIAL SERVICES**
- **FORMAL CROSS-SITE LINKING**
- **COMMUNITY RESOURCE DEVELOPMENT**
- **CLIENT PARTICIPATION**
- **TEAM COLLABORATION AND DECISION MAKING**
- **FLEXIBILITY AND CHOICE**
- **NO COST SHIFTING**

RATIONALE FOR CENTRAL ROLE OF GNP

- **TRAINED TO MANAGE COMPLICATED MEDICAL PROBLEMS**
- **TRAINED TO COLLABORATE WITH MEDICAL PRACTITIONERS (SPEAK THEIR LANGUAGE)**
- **TRAINED TO MANAGE SPECIAL PROBLEMS OF ELDERLY LEADING TO INSTITUTIONAL USE**
- **PRACTICE SAFETY, EFFECTIVELY, AT LOWER COST, GREATER PATIENT SATISFACTION**
- **WILLING TO WORK IN UNDER-SERVED AREAS (REPLICABLE) SHOWN TO CHANGE PRACTICE PATTERNS OF PHYSICIANS**
- **SHOWN TO REDUCE HOSPITAL ADMISSION, READMISSION, NH USE AND DAYS**

III
REJECTED MODELS:

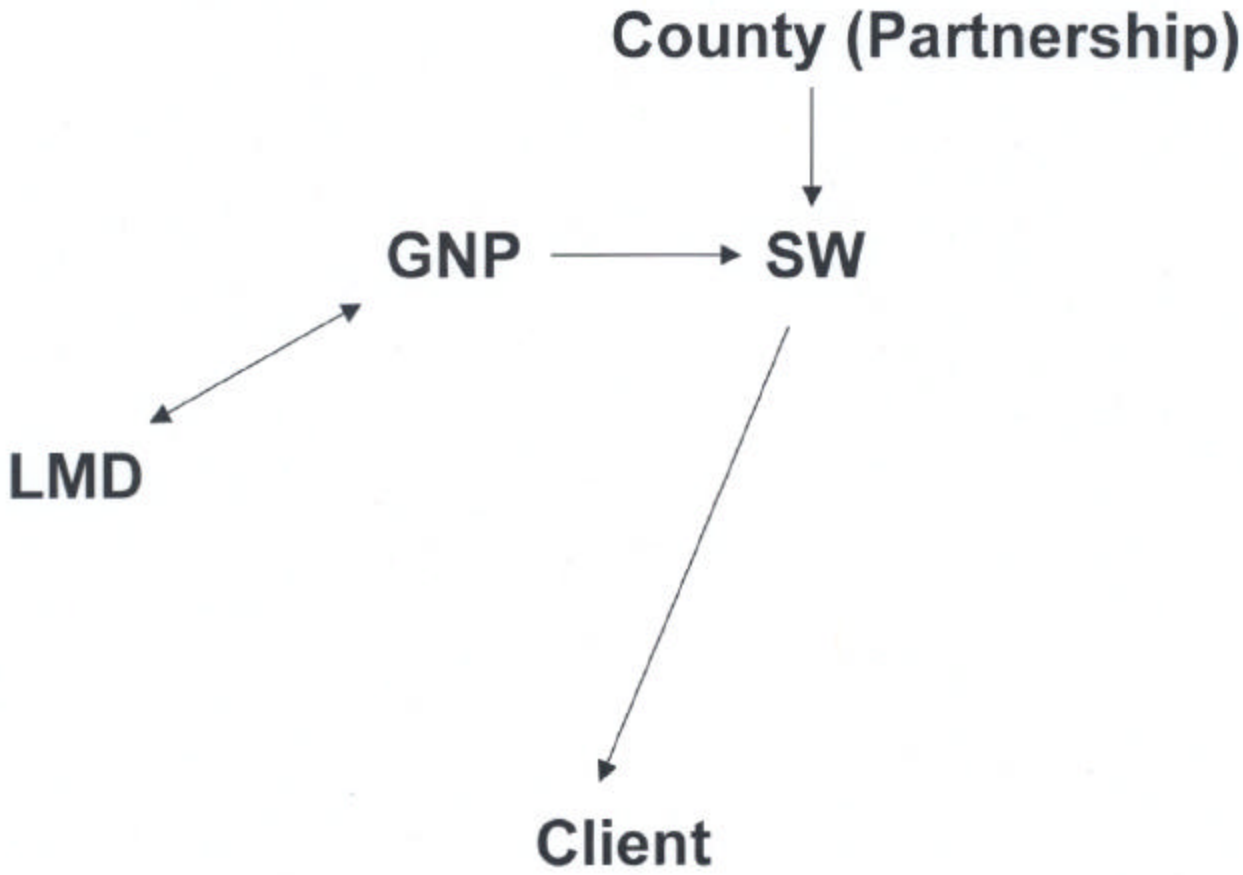
Description and Discussion


Partnership
County
GNP
SW
LMDs
Client

Model I

This model assumes no relationship between PACE and Partnership. Social workers remain county employees, continuing to have control over social and supportive services (much the same way it currently operates). The GNP has control over (along with LMD) a capitated pool of health care/medical dollars. The GNPs and SWs are housed in, employed by, and accountable to separated agencies. Collaboration is informal, and dependent on the GNP and SW creating a working relationship around their mutual clients. The GNPs and SWs would not necessarily use the same referral networks or subcontractors. The pool of workers developed (eventually) by the Partnership Program would not necessarily be used by the SWs. The model was rejected because it leads to:

- Minimal or no collaboration on decisions
- Multiple entry points for consumer
- Divides resource utilization authority and encourages cost shifting
- Diminished possibility for prevention/early intervention in serious medical conditions
- Separates community workers (PCWs) from clinical team
- Disrupts communication among providers
- Increases the number and diversity of worker pools, undermining staff training and supervision
- Increase the contact points between other community providers and Partnership providers



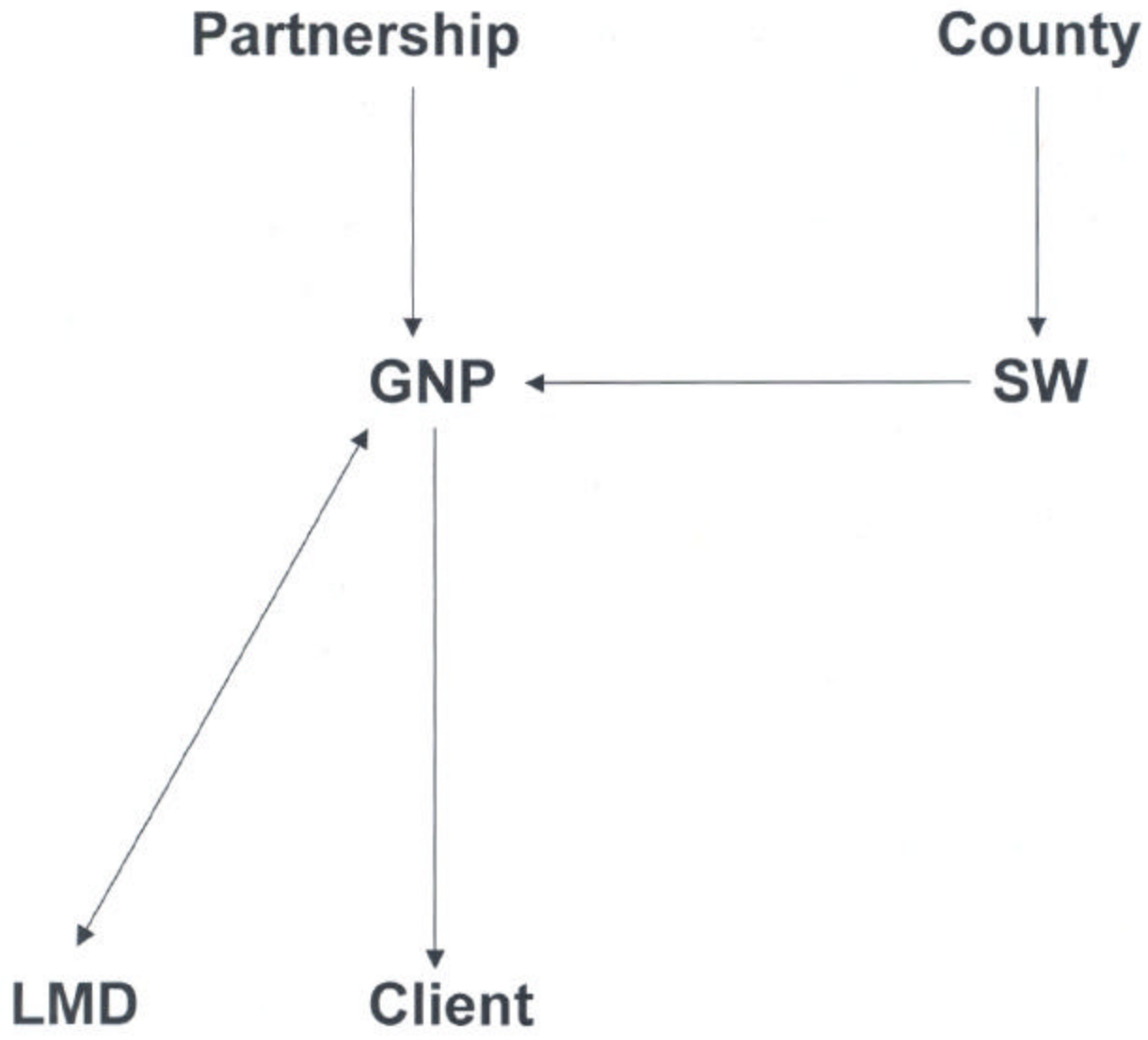
Client

Model II

In this model, resources are controlled by the county. The social worker/case manager is final decision maker in consultation with the GNP. The GNP is physically housed with social workers, but not an employee of the county. The GNP is the primary link to the LMD.

This model was rejected because:

- Undermines collaboration among Partnership team members since there is no necessity for true collaboration between GNP and SW in this model.
- Results in multiple contact/entry points for consumers or non-Partnership providers
- Funding, resources utilization, authority is split
- The GNP acts as a consultant intervening by referral only. This minimizes the effectiveness of early intervention/prevention and LMD collaboration
- The community workers (PCWs) are not closely associated with or supervised by the Partnership clinical team; minimizing communication, and input from personal care workers' training and evaluation while undermining the effectiveness and consistency of evaluation
- Results in multiple service plans for each consumer


Partnership
County
GNP
SW
LMD
Client

Model III

In this model resources are controlled by Partnership. The GNP is the final decision maker in consultation with the SW and LMD. This model was rejected because of the:

- Minimal or no collaboration between the GNP and the SW
- Disrupted communication due to physical separation of clinical team members
- Multiple entry/access points for consumers and other providers
- Redundancy in communication with local physician (LMD)
- Results in multiple service plans for each consumer

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